Maryland Cancer Plan
Pain Management Committee

IDEAL MODEL FOR CANCER CONTROL	• **Definition**: Therapeutic interventions to manage pain including pharmacologic (long and short acting analgesics & adjuvants), and non-pharmacologic and interventroval procedures (i.e.: strontium, pamidronate, temporary & permanent blocks, etc.). • **Access** to affordable and convenient pain management services for all cancer patients in need. • **Extension of cancer pain to all pain:** Whereas cancer pain consists of acute and chronic pain and the barriers to adequate assessment and management of cancer pain do not differ from pain management in non-malignant conditions, and the overarching principles of assessment and management are similar, we encourage that the recommendations in this document be extended to the management of acute and chronic pain associated with non-malignant conditions. • All interactions occur with consideration to issues of disparity and cultural, religious, language, and age barriers of patients. Adapt statement from Last Acts website: *All individuals' life experiences contribute greatly to the complexity and uniqueness of the end-of-life issues that we all face. These experiences, as much as anything, shape our desires and beliefs about health, illness, death and dying. The **Diversity** Committee advocates recognition, acceptance and support of its recommendations concerning individuals' experiences with race; historical oppression; war and its aftermath; cultural, religious and spiritual practices; affectional orientation; discrimination and poverty. The true meaning of diversity (especially as it affects the end of life) is as much about these unique, view-shaping experiences as about the narrower, yet more common concept that focuses on ethnicity or religion.* • All interactions occur with attention to the Patient's **Rights & Responsibilities**, including informed consent, as well as the rights & responsibilities of the provider and the health care system • On-going **public and provider education** regarding pain assessment and management. • Coverage for pain assessment and management by all **insurance** providers. • On-going **research** into pain assessment and management.

PROBLEM or ISSUE	**SOLUTION or RECOMMENDATION**
Lack of provider awareness regarding appropriate pain assessment and management and relevant policy	Nursing and Medical students should receive both didactic and clinical application to pain management. ➢ Clinical rotation modules

From "Hit List"- Are all of the below included as we have addressed provider education? •Understanding when to use pain meds •Prescribed dosage differs between disciplines, ineffective prescriptions •Pain management vs. overdosing, physician perception and concerns about oversight, fear of consequences for prescribing •Matching meds with certain kinds of pain •Inadequate post-graduate training	Residents should be required to view the Board of Physician Quality Assurance (BPQA) video, "A Sense of Balance," before receiving licensure OR make the video part of the BPQA orientation program • A Sense of Balance, is a videotape presentation on drugs, chronic pain, and related subjects including appropriate prescribing of controlled drugs, over prescribing, the addicted physician and identifying the drug seeking patient. This video presents the position of the Maryland Medical Board as well as that of the Federation of State Medical Boards on prescribing to patients with pain. • This video should be digitally transferred to the web for ease and increased access. Educate licensing Boards for Maryland health care providers regarding pain management. This includes, but is not limited to the Board of Physician Quality Assurance, the Board of Nursing, and the Pharmacy Board. Each board should develop a statement about the practice's role in pain assessment and management, including minimum competencies and education requirements. Providers should be required to view the statement prior to licensing. Thus, the statement should be made available through the web in a user-friendly format. Licensing Boards should also be encouraged to treat transgressions of untreated or under-treated pain with the same care as over-treatment. In addition, all healthcare providers (including, but not limited to, physicians, nurses, and pharmacists) should be required to have earned continuing education credits in the area of pain assessment and management before re-certification is issued. (I believe we actually decided to strike this last requirement in the 7/29 meeting but wasn't sure) Practicing physicians/specialists should be offered a discount on

	malpractice insurance for continuing education in the area of pain assessment and management All educational initiatives targeting providers or institutions regarding pain assessment and management should contain information regarding relevant policy and new legislation. Targets for this comprehensive education regarding pain assessment and management include: hospitals and other provider institutions, Ethics Committees, nursing home administrators and Ombudsmen, State surveyors of nursing homes, Medicaid assessors, and the Inspector General. In addition, statewide professional organizations should be encouraged to provide professional education about pain and its assessment and management.
Lack of reimbursement from insurance companies for pain therapies	Modify State regulations to facilitate availability and prescribing of pain medications. Needs refinement Seek a mandated Pain Assessment and Management benefit for insurance companies who provide insurance in Maryland. This benefit would allow for referral to a pain specialist for pain assessment, treatment, and follow-up, including management of side-effects. This benefit can be mandated via the Insurance Commission or legislation.
Nursing homes are not held to standards for pain management	Nursing homes not accredited by JCAHO should be held to similar standards by the State licensing agency (this is the Office of Health Care Quality) for pain assessment and management.
Significant barriers to pain management exist for low-income patients, including requirement of prior authorizations for certain drugs, particularly in the Medicaid system, and significant cost of pain therapies.	Convene an independent council to review and determine prior authorization status of drugs used in pain management. Extend assistance for payment for pain medications for financially compromised at X% above poverty levels.
Lack of scientific knowledge regarding…	Encourage and promote research into the following areas: • Validation of lower-cost medications • Outcomes analysis, longer term use of opioids • Complementary and alternative therapies

	• Needs assessment for Maryland • Pediatric pain management • Practice changes
Lack of public knowledge and awareness of pain management practices	Partner with organizations such as the Maryland Pain Initiative, the American Pain Foundation, and the American Chronic Pain Association to conduct a comprehensive, statewide, and culturally sensitive educational media campaign to promote pain assessment and management. The message should focus on the patient's right to adequate pain management and responsibilities in the process, dispelling the myths about pain medications, that options exist for pain management, and calling for patients to communicate with their health care provider about pain. Promote outreach to consumer/patient groups focused on pain. Standardized, on-going dissemination of information on specific pain medications to patients, possibly recommend use of ACS materials already in existence (from pharmacy or provider?).
Patient non-compliance due to: •cost of and lack of reimbursement for pain management services (especially outpatient visits) •fear of addiction and/or side-effects •confusion stemming from media sensationalism •cultural and family influence	
Lack of knowledge and reimbursement for complementary and alternative therapies	Recommend support for scientifically validated complementary and alternative therapies for pain control as individual measures or in conjunction with traditional pain management methods. Support research in this area, encourage patients and providers to discuss these therapies, and advocate for reimbursement of these therapies by insurance companies. Use NIH definition: Complementary and alternative medicine, as defined by NCCAM, is a group of diverse medical and health care systems, practices, and

	products that are not presently considered to be part of conventional medicine.[1,2] While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies—questions such as whether they are safe and whether they work for the diseases or medical conditions for which they are used. • Complementary medicine is used together with conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a patient's discomfort following surgery. • Alternative medicine is used in place of conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a conventional doctor. Source : http ://nccam.nih.gov/health/whatiscam/ The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge.
Inadequate assessment and assessment tools for pain	Promote the use of standardized, valid, and reliable assessment tools for pain assessment. In assessing pain, the intensity of the symptom should be monitored as well as the effect of the pain on the patient's function.

Ordering of pain medication "As-needed" is a problem for patients who have a limited ability to advocate for themselves and ask for pain medication (to include children, patients with dementia, patients with language barriers).	
Need for attention to pain services in advance directives Issue of double effect	Recommend that all advance directives include some mention of the person's preference regarding pain control and comfort measures and encourage the person to have a discussion with their health care proxy regarding specific measures. Consider advocating for changes to the form used in Maryland for Appointment of a Health Care Proxy.
From the "Hit List" Medication abuse: Medications stolen or sold for use other than patient's Reporting that medications aren't working to get higher doses prescribed	
From the "Hit List" Access: Willingness of pharmacists to stock drugs Drug companies priorities in R&D Legislative structuring (don't know what this refers to, might be included above in insurance section)	

Items mentioned that need further attention:

1. Using California laws as the model; more research needed into current MD regulations
2. Who to contact for cases of uncontrolled pain, and if this should be part of the recommendation for public education or left as-is (statement that licensing boards should discipline cases of under-treatment as much as over-treatment)
3. Encouraging the establishment of multidisciplinary pain centers and adopting standards to be considered a specialist, pain center
4. Governor's Pain Management Council- any need to interact or submit our recommendations? How to do this?